

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 22, 2004
10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Public comment

MR. KALMAN: Hello, my name is Ed Kalman. I'm general counsel for the National Association of Long-term Care Hospitals and I have two comments I would like to make. With regard to slide three which was a comparison of Medicare expenditures to different sites of care, acute hospitals and other post-acute levels of care I'd like to note that the long-term care hospital PPS system has a short-stay policy. That is the standardized is not applicable to all patients. CMS has stated in the preamble to its update rules that that's approximately 50 percent of the patients.

So therefore, in setting forth Medicare payments to these providers I would think it would be important that the entire payment system be referenced. For acute hospitals payment equals the standardized times the weight and certain other adjustments. For long-term care hospitals that's not the case. It's the standardized amount times the weight and a short-stay policy. So I would hope that you would consider that.

My second comment goes to the discussion on rehabilitation which I thought was quite constructive. It is the case that there are long-term care hospitals that are community resources, and this is mostly freestanding long-term care hospitals, that serve rehabilitation patients, both sick rehabilitation patients and comprehensive rehabilitation patients. Disrupting them in their communities could have significant adverse effect on patterns of care. I want to underscore to you so you understand that. That means patterns of care as to crossover patients, because these institutions take care of long-stay patients many times that are on the juncture between Medicare and Medicaid, which is not a very hospitable place to patients. You're going to be discussing that this afternoon.

I do think, however, that the notion that these patient should be paid the appropriate rate is extremely important. When you discuss that in that portion of the chapter I would hope you would have some consideration to allowing these facilities to continue and to be paid for these patients and an IRF PPS rate in rehabilitation units within their hospitals, for which there is a need for congressional authority.

Otherwise, I'd like to state our association's complete agreement with the notion that there should be clearly-defined criteria. We're very happy that the staff has chosen to reference the QIOs as a vehicle and note that they can get up and running very soon.

Thank you very much.

MR. LAUGHLIN: Good afternoon, I'm Rod Laughlin. I'm president of Regency Hospital Company in Atlanta, Georgia. We operate 11 hospital-in-hospital LTCH hospitals around the country. I want to address the issue that these patients are routinely treated in the short-term acute-care hospitals.

It really gets back to your definition of treatment. I can

look, and I do routinely every day when I decide where to look for an opportunity to build a new LTCH hospital, I pull the MedPAR data and I look at all the discharges for Medicare and commercial and everything else, and I look by length of stay and by DRG. There are about 175 different DRGs that an LTCH would typically treat so I can routinely access that data for people who stayed 15 days or more, 20 days or more, and what have you.

What I find that's proven true in looking at hundreds of hospitals across America is that 2 percent to 3 percent of their med-surg discharges will fall into the 175 DRGs that an LTCH could treat, and if you look at 15 to 20 days or longer, that group of people will have an average length of stay of between 24 and 26 days. It happens so often using those parameters that it's just amazing.

What that means is that depending on the size of the hospital that we're dealing with, there are routinely 200 or 300 patients in that hospital that could benefit, apparently, by being in an LTCH, because they have some medical condition, often just simply multisystem failure which is very difficult to treat, that means they don't respond in the short-term hospital.

What we have found in the LTCH that makes a difference in the outcome -- and by the way, I'm getting an average of 55 percent to 65 percent of these patients home, I'm sending another 25 percent to SNF or rehab as quickly as they're medically strong enough to go. We are losing 11 percent to 12 percent, which is substantially better than the industry average of about 30 percent, and we're getting those people home because of the nursing hours and the respiratory therapy hours and the multidisciplinary program we're applying.

I am delivering, and Mutual will verify the fact that we have the highest case-mix index of the patients in the country. I have hospitals routinely just under the new PPS system treating a 1.4 to a 1.65 case-mix index, which is very, very high. We're selecting the sickest patients we can find from the post-hospital and anybody else who refers in that community, and we're getting a substantial group home. But it's because I deliver eight to 12 nursing hours per patient day. And that's not aides. That's all licensed people -- based on the acuity of the individual patient. I also deliver five hours of respiratory therapy per respiratory day and two hours at PT/OT and speech across the total patient days. We run this program seven days a week. It doesn't slack off on the weekend. We're selecting very, very sick people and we're getting great results.

I believe that these criteria are the right direction to go because they will eliminate some abuses that I know very well, being in this industry, in certain LTCH hospitals. The PPS system is also going to eliminate some abuses and change behavior over time in the future.

What I would say to you today is, I don't know how you can make these decisions without getting the data on outcomes. Commissioner DeParle said, I would be willing to pay more for better quality. When I started in the LTCH business in 1992, obviously I saw that it was about saving short-term hospitals some money for patients that don't fit their mission, that

require things they're not set up to provide. But what I have come to understand is that a properly-run clinical program in an LTCH can get great outcomes for people and give them their lives back.

If you just throw money at the short-term acute PPS without requiring a change in the way those hospitals treat these patients, you won't get a difference in the outcome for people. I am in the LTCH business and I'm passionate about it because I've seen people get their lives back that were not responding even though they were in some of the best tertiary care hospitals in America. It's that 2 percent to 3 percent that we need to look at differently and I applaud you for going through the studies to get this information.

Thank you.

MR. HACKBARTH: Okay, we'll reconvene at 1:30.

[Whereupon, at 12:45 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

